26. *On Certain Forms of Fistula in Ano, with reference chiefly to their Treatment without dividing the Sphincter Muscles.*—Mr. Hird read, Oct. 20th, before the Medical Society of London, a paper on this subject, and also gave his opinion in favour of the treatment of many special cases of complete fistula by means of the ligature. After alluding to the painful and hazardous operations practised by surgeons for the cure of fistula until a more correct view was taken of the disease by Percevall Pott, by whose influence and example the barbarous treatment at that time had recourse to was renounced by the profession in this country, the author gave a minute description of the anatomical structure of the lower part of the rectum, and of the tissues which fill up the ischio-rectal fossæ, and observed that many obscure collections of matter can only be diagnosed by those who are familiar with the complicated fascial and muscular boundaries of the space surrounding the extremity of the gut. Mr. Hird then described the varieties of spontaneous abscess which affect this region, and gave the result of several cases of fistula which had not entered the rectum, or laid bare its walls, in which no operation was performed; and strongly opposed the assertion made by Mr. Syme, and many other surgeons who have written on this disease, "that all remedial measures, except the knife, are ineffectual." As a preventive treatment against the formation of fistula, he urged the necessity of freely laying open all abscesses in the neighbourhood of the rectum before the walls of the bowel are laid bare. The incision should be directed from before backwards, and not transversely, so that the discharge may have no mechanical difficulties to overcome in its exit. When the abscess does not close by the ordinary process of granulation, Mr. Hird advises the use of mild injections of nitrate of silver (four grains to the ounce), and the application of well-adjusted pressure on the part. In two cases of eight and ten years' standing in which this treatment was not successful, he effected a cure by means of a platinum wire heated by electricity, and connected with the poles of a galvanic battery, similar to the one used by Mr. Marshall for applying electric cautery to fistulous openings in the cheek, and advises the use of this agent before resorting to division of the septum. In cases of complete fistula, the author has no confidence in any treatment except that of laying the cavity of the abscess and of the rectum into one by dividing the sphincters. This, he said, might be accomplished either by means of the knife, the ligature, or electric heat. Although the knife is the favourite instrument of the majority of surgeons, he prefers the use of the ligature in all cases where the hemorrhoidal veins are unusually large, or when the patient has a dread of the knife. He considers also that this method of operating possesses advantages over the knife in many special cases, and, if judiciously applied, and only tightened by means of the fistula-tourniquet to a degree of tension sufficient to accomplish the division of the septum, is not so painful as the operation with the knife, less so in the after-treatment, and frequently accomplishes a cure in a shorter space of time. Hemorrhage and the dread of a cutting operation are avoided by this plan. Mr. Hird's experience does not confirm the opinion of Sir B. Brodie, that all fistulæ have an internal orifice leading into the rectum; neither do his observations verify the opinion of many writers, that fistulæ are most frequently found in phthisical patients; but, on the contrary, are in harmony with the views of Andral and Louis, both of whom demonstrate, by statistical inquiries, that these affections, occurring simultaneously in the same individual, are merely the result of accident, and that they do not stand to each other in the relation of cause and effect.—*Med. Times and Gazette*, Oct. 27th, 1855.

27. *Dislocation of the Humerus backwards into the Infra-spinous Fossa.*—Dr. Maurice H. Collis relates (The *Dublin Quarterly Journal of Med. Science*, Aug. 1855) an interesting case of this extremely rare dislocation, which presented itself to him in October, 1851, at the Meath Hospital.

"The subject was an old woman, very thin, with weak flabby muscles. The accident occurred thus: as she was walking along the pathway, with a bundle under her arm, she slipped off and fell forwards on her shoulder; she immediately came up to the hospital, feeling that her shoulder was hurt.

"Upon stripping the shoulder the very remarkable symptoms of dislocation backwards were at once readily perceived. In place of the natural rounded prominence in front, there was a deep depression or pit, into which the finger could be pressed; there was flattening of the shoulder on the outer side, below the acromion, and a large rounded prominence was felt at the back of the scapula, below the spine. This prominence was subcutaneous, and was easily ascertained to be the head of the bone, upon rotation of the arm. The elbow projected forwards and a little out from the side; the axis of the limb ran from the prominence above mentioned downwards and forwards; the length of the limb, from the tip of the acromion to the point of the elbow, was not altered. The patient was either unable or unwilling to attempt motion of any kind, and when desired to do so she moved the scapula on the trunk. We were, however, able to rotate the arm freely, to approximate it to the side, and to bring it forward. We could not raise it or bring it in a backward direction without rotation of the scapula. In our manipulations we experienced no difficulty from the occurrence of tumefaction or effusion, owing to the recent nature of the accident, nor did the patient complain of much pain. The dislocation was readily reduced. Mr. George Porter made extension by raising the arm to a right angle with the body, and drawing it outwards and slightly forwards, at the same time rotating it. I fixed the scapula with the palms of my hands, and made pressure on the displaced head of the bone; with very slight effort the bone returned to its natural place, and the symptoms of dislocation disappeared. The patient recovered the use of her arm at once, and did not return to the hospital.

"All surgical authorities are agreed upon the extreme rarity of this form of dislocation—not more than eight or ten being on record. Boyer attributes this rarity to the fact that muscular action has no part in bringing about this dislocation. According to him the accident occurs by a fall on the side with the arm extended and advanced; and it will require a very considerable force to be applied to the elbow before the bone can be thrust outwards or backwards; it is manifest, however, even when the accident occurs in the manner described by Boyer, that the action of the muscles, which attach the scapula to the trunk, largely assist in producing the dislocation. By these muscles the scapula is fixed, while at the same moment the humerus is converted into a powerful lever of the first order. Its centre rests on the side of the chest, the violence is applied at the elbow, and it is only when this violence is sufficient to rupture the capsule, and overcome the action of the muscles about the capsule, that dislocation can occur. The muscles which fix the scapula assist in causing the accident, for if the glenoid cavity were not fixed by them, the violence applied to the elbow would cause it to follow the head of the bone in its movements, and render dislocation impossible. The possibility of dislocation by a direct blow on the front of the shoulder does not appear to have struck Boyer, nor do I well know how to account for its producing dislocation in the present instance, unless by supposing that the glenoid cavity was altered by age and rheumatic disease. It is well known, these causes are sufficient to flatten the cavity, and give it a greater breadth in the backward direction. In the London Medical Gazette for 1833 a somewhat parallel case will be found, in which an old woman, falling on the front of the joint, dislocated it backwards. From the feel of the joint, when reduced, both Mr. Porter and I were of opinion that the dislocation would be easily reproduced; the patient, however, never returned to the hospital, and we are ignorant of her subsequent history. I have thought it right to put the case on record, as the accident is rare; but I regret that I am not able to throw more light upon what may be called the mechanism of its occurrence."

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28. *Treatment of Fractures by the Starched Apparatus.*—Benjamin Hunt has published, in the *Association Medical Journal*, reports of thirty cases of fracture, taken indiscriminately from amongst many others treated in like manner at the Queen's Hospital, Birmingham. We present a tabular view of these cases, with the remarks of the author:—